STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF CHILD WELFARE LICENSING

NICK LYON
DIRECTOR

June 12, 2018

Nathan Cox
Starr Commonwealth
13725 Starr Commonwealth
Albion, MI 49224-9580

Amended from the May 18, 2018 Report

RE: License #: CI130201440
Investigation #: **2018C0103021**
Starr Commonwealth

Dear Mr. Cox:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- **For any repeat violations, include an assessment of why the previous corrective action plan was ineffective.**
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9740.

FOR CWL ONLY
Please note that violations of any licensing rules are also violations of the MSA and your contract.

Sincerely,

Rorie Dodge-Garnaat, Licensing Consultant
MDHHS\Division of Child Welfare Licensing
235 Grand, Ste 407
P.O. Box 30650
Lansing, MI 48909
(517) 899-6024

enclosure

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF CHILD WELFARE LICENSING
SPECIAL INVESTIGATION REPORT – AMENDMENT

I. IDENTIFYING INFORMATION

License #:	CI130201440
Investigation #:	2018C0103021
Complaint Receipt Date:	01/24/2018
Investigation Initiation Date:	01/24/2018
Report Due Date:	03/25/2018
Licensee Name:	Starr Commonwealth
Licensee Address:	13725 Starr Commonwealth Albion, MI 49224
Licensee Telephone #:	(517) 629-5591
Administrator:	Elizabeth Carey, Designee
Licensee Designee:	Elizabeth Carey, Designee
Name of Facility:	Starr Commonwealth
Facility Address:	13725 Starr Commonwealth Albion, MI 492249580
Facility Telephone #:	(517) 629-5591
Original Issuance Date:	04/01/1991
License Status:	REGULAR
Effective Date:	09/02/2016
Expiration Date:	09/01/2018
Capacity:	240
Program Type:	CHILD CARING INSTITUTION, PRIVATE

II. ALLEGATION(S)

	Violation Established?
A resident claimed she was restrained on glass.	No
A resident said she was elbowed in the face by Mr. Burch.	Yes
A resident indicated she was elbowed in the face by Ms. Hunt.	No
Additional Findings	Yes

III. METHODOLOGY

01/24/2018	Special Investigation Intake 2018C0103021
01/24/2018	Special Investigation Initiated - On Site Youth A, Youth B, Nate Cox, Randy Copas
01/24/2018	Contact - Telephone call received DHHS Worker
01/24/2018	Contact - Telephone call made DHHS
01/24/2018	Contact - Document Sent DHHS
01/24/2018	Contact - Document Sent Area Manager
01/31/2018	Contact - Face to Face Youth A, Youth B, Ms., Collins, Mr. Johnson
02/07/2018	Contact - Face to Face Personnel file review for Mr. Burch and Ms. Hunt
02/13/2018	Contact - Face to Face Mr. Burch, Mr. Cox, and Mr. Copas
02/13/2018	Exit Conference

02/28/2018	Contact - Face to Face Interviewed Ms. Fisher, Ms. Hunt, and Mr. Hadley
02/28/2018	Inspection Completed-BCAL Sub. Compliance
04/13/2018	Contact – Telephone Conference call with Starr
05/08/2018	Contact – Document received E-mail from Area Manager

ALLEGATION:

A resident claimed she was restrained on glass.

INVESTIGATION:

At the facility on 1/24/18 Youth A was interviewed for a different investigation. She stated she has had issues with a staff member named Mr. Burch. She stated her and another resident were tearing up the cottage when Mr. Burch went up and grabbed her and dropped her on the floor. She stated he was leaning over her throat and she could not breathe. She also stated the restraint took place in glass and when someone offered to clean up the glass Mr. Burch said she deserved to be restrained on glass. She stated this incident happened 3 weeks ago and Mr. Burch lied on the Unusual Incident Report (UIR) and said they fell.

Nathan Cox, Starr Commonwealth, was asked about the restraint that occurred with Youth A by Mr. Burch. He reported he really doesn't know a lot other than what was on the incident report. He did report that the girls had successful truancies on New Year's Eve when the girls realized pulling the fire alarm creates 15 seconds delayed egress. The girls were destroying the unit and trying to access the fire alarm.

Conversation occurred with Nate Cox and Executive Director Randy Copas about the allegations made and that the allegations would be reported to DHHS for investigation. They were advised to have Mr. Burch moved to a different cottage until the investigation is concluded.

On 1/31/18 Youth A was interviewed, this time by the DHHS Worker. She stated she had an issue with Mr. Burch when he restrained her on glass. She stated she was in the dining room and four other girls were “destroying” the cottage. She said Mr. Burch picked her straight up off her feet and laid her down on the floor. She stated Mr. Burch put his hands on either side of her waist in order to lift her straight up. She stated she “fractured” her knee during the restraint and she was set down on glass,

which cut up her back. Another resident asked to clean up the glass for him and Mr. Burch stated not to because Youth A deserved to be restrained on glass.

Youth A stated there was glass on the floor because the table had been flipped over and it had plates on it. She said Mr. Burch placed his elbow in her neck so she could not breathe. When the other girls said something about her not being able to breathe Mr. Burch said she deserved it.

At the facility on 2/7/18 personnel files were reviewed. Davante Burch had Safe Crisis Management (SCM) training on 7/13/17. The only discipline in his file was due to punctuality.

The DHHS Worker Interviewed Youth C on 2/8/18. Her notes are summarized below:

> Youth C was interviewed. Youth C stated prior to Youth A being restrained by Mr. Burch she had flipped a table and Youth D had flipped a table as well. Youth A was flipping food and plates off the table and flipping chairs. She said this happened right after dinner and when the tables were flipped the glass broke. She reported Mr. Burch restrained Youth A. Youth C said Mr. Burch tried to get Youth A down but she was struggling so he put her in a supine restraint. She reported he was then on Youth A's chest and she was turning purple so Youth C told him to get off Youth A. When asked how he was physically trying to get Youth A down she reported his arms were holding her arms. She said Youth A was fighting him by trying to wiggle out of his arms. Youth C said Mr. Burch restrained Youth A on the glass and she was cut as a result. Youth C said she saw the glass around Youth A and asked to pick it up. She reported after the restraint she saw the cut on Youth A's upper back. During the restraint Youth C asked if she could pick up the glass. She reported Mr. Burch told her to leave the glass but she picked it up anyways. Youth C said she saw the scratches on Youth A's back. She reported they weren't bleeding but she could tell they were scratches. Mr. Burch, Ms. Schleede and one other staff were working. She reported it started with Youth D pouring milk everywhere because she was mad about her medication. She reported they had all stopped acting out Mr. Burch still decided to restrain Youth A. She said she doesn't know why Youth A was restrained and not them. She reported some of the group watched what happened and some went back to their rooms but she is not sure which ones were where. She reported Ms. Schleede was there at the start of the incident. She reported she knows there was a staff by the entrance that could get out off and she wasn't sure where the other staff was. She reported by the time back up got there the restraint was already over.

The DHHS Worker also interviewed Youth F on 2/8/18. Her notes are summarized below:

> Youth F was asked if she was aware of any restraint that occurred in the dining room and she reported she was but she hasn't been there for some. When asked about the last time she reported it involved Youth A, Youth C, and Youth D. She

said Youth D was at the table and poured all the milk out on the table. Staff said they never listen and the girls said they would "show you acting up". The girls then started throwing things, pulling fire alarms, trying to run out of the cottage and flipping tables. Youth A and Youth C were trying to pull the fire alarms; Youth A was throwing food on the floor and the other girls were throwing plates. Mr. Burch then restrained Youth A. She reported he went to put her down but Youth A was trying to get up by sitting up, pushing him, kicking him and yelling. Mr. Burch tried again to get her down. Youth F stated both these times she believes he was using his arms to hold her arms. The second time Youth A tried to get up the same way, so he then slammed her on the floor. When asked what this meant she reported he used his hands on her waist and put her on the floor.

Youth F stated Youth A started crying. The rest of the girls were then told to go back to their rooms. The only ones that stayed in the front of the cottage were Youth A, Youth C and Youth D. Youth F said she heard Youth C and Youth D yelling at Mr. Burch to get off Youth A.

Youth F said she could not remember what other staff were there. She reported the girls were throwing plates at people and on the floor. She believed Mr. Burch got hit in the head with one of the plates. When the plates were thrown on the floor they would break. Youth F reported Mr. Burch restrained Youth A in the same area where the glass was broke but it wasn't on the same spot where the glass was broken. When asked if anyone was hurt she reported that Youth A had some scratches on her back. Youth A told Youth F the scratches were from the glass scratching her. Youth F said the scratches were just regular red scratches. She reported she kept the girls from pulling the fire alarms by standing in front of the alarm herself. She remembered two staff were standing by a door blocking the girls from running out, but could not remember who the staff were.

On 2/13/18, along with the DHHS Worker, staff member Davonte Burch was interviewed. In regards to the incident with Youth A. Mr. Burch stated there were three staff on shift; Himself, Ms. Collins, and Ms. Schleede. Mr. Burch stated Ms. Schleede was by the exit door, Ms. Collins by the fire alarm and he was dealing with the girls in the dining area. He stated four of the girls (Youth A, Youth C, Youth D, and another youth) were throwing chairs and tipping over the tables. Youth A went to grab a chair to throw it and Mr. Burch went to restrain her. The two of them slipped on milk and ended up on the ground. Mr. Burch said he put Youth A in a sort of modified Supine restraint. He stated Supine restraints are to be done with two people but because there was no other staff who could and they had fallen to the ground, he ended up in a one person hold, which was half of the hold with Youth A’s one arm across the front of Mr. Burch’s body with his back to Youth A. Mr. Burch did not notice they were on the broken plates until after Youth A got up. He stated he did not think there was any broken pieces where he restrained Youth A because the plates were thrown on the other side of the table from where the restraint occurred.

Mr. Burch stated he and another staff called for assistance multiple times. He said they tried calling before chairs were thrown. He stated when the girls heard extra staff was called they started to throw chairs.

An interview occurred with Ms. Vondy via telephone on 3/19/18. She stated there have many incidents of the girls flipping tables and she could not say what shift those occurred on. She said she never saw Mr. Burch restrain Youth A in a one person supine nor has she ever seen Youth A restrained on glass.

Ms. Schleede was also interviewed via telephone. She stated she recalled the incident with Youth A and the tables being flipped. She recalled that she was sitting by the exit, Ms. Collins was standing by the fire alarm and Mr. Burch was dealing with Youth A who had begun to flip over tables and throw dishes. She stated when the girls first started to show signs of acting out they called for an additional staff but no one was able to come. She stated Mr. Burch tried to restrain Youth A in a standing hold but with Youth A struggling and the milk spilled all over the floor he was unable to maintain the hold and they fell to the ground. At that time Mr. Burch placed Youth A in a supine hold on his own. She said this is not allowed but Mr. Burch did what he had to do. She also stated Mr. Burch did not intend to restrain Youth A on glass. She said the restraint started away from the glass but during the struggling they ended up on the broken plates.

Ms. Schleede stated there was only three staff on shift that night and that was not enough staff. She stated the girls on Youth A's unit require four or five staff in order to deal with their behaviors.

A medical statement from the nurse was provided. Youth A was seen by the nurse on 1/9/18. Youth A had complained of jaw pain and scratches on her back. The nurse wrote that there were "two superficial excoriations" to Youth A's upper back. Also, there was no bruising, redness, or swelling of her jaw. No other physical complaints were indicated.

APPLICABLE RULE	
R 400.4159	**Resident restraint.**
	(2) Resident restraint shall be performed in a manner that is safe, appropriate, and proportionate to the severity of the minor child's behavior, chronological and developmental age, size, gender, physical condition, medical condition, psychiatric condition, and personal history, including any history of trauma, and done in a manner consistent with the reside-nt's treatment plan.
ANALYSIS:	Mr. Burch stated he did not know that Youth A was laying on the glass pieces of plate when she was placed in a restraint. There is no indication that if Youth A received scratches from the

	glass, it was intentional as it was reported the plates were broken on the other side of the room.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

A resident said she was elbowed in the face by Mr. Burch.

INVESTIGATION:

At the facility on 1/31/18, along with the DHHS Worker, Youth B was interviewed. Youth B was very unhappy about the meeting and stated it better be "snappy." She was given a break in hopes of returning in a better mood but that was not the case. Youth B started off saying she could not remember anything, but when asked, she said staff got mad and started elbowing her in the head and jaw. She said he almost knocked her teeth out and bruised her throat. She said she did not remember when this occurred and said it does not matter because the staff has been moved.

Youth B stated Mr. Burch was the staff member. He came in to Youth B's room and told her to leave her room. When Mr. Burch sat in a chair in the hallway outside her bedroom Youth B threw a blanket at him. Youth B threw the blanket at Mr. Burch again and he got up and walked into her room. Youth B said she told him to get out as he was not supposed to be in her room alone. Youth B said Mr. Burch stood by her bed while she was on the bed. He then started trying to restrain her. She then said she could not remember the details of the restraint, saying it was too much for her to remember.

Youth B did state that Ms. Collins was present during the restraint and that Ms. Collins was trying to get Mr. Burch away from Youth B. She stated Mr. Burch was shoving her face into the bed so she could not breathe. Youth B stated she could only remember bits and pieces and that Mr. Burch made her "spit up blood."

Youth B stated whenever she would try to sit up Mr. Burch would elbow her in the face. She stated Mr. Burch was sitting on top of her. She said she was swinging at him. She stated Ms. Collins was able to get Mr. Burch off of her. Mr. Burch then left to "throw a temper tantrum." Youth B said she had a bump on her head and received ice for it. She said her head, jaw, and neck all hurt. She stated Mr. Burch had placed pressure on her neck causing her to not be able to breathe. She stated while on the bed she was on her side and back. She also stated she was suffocating on the bed. She said she was suffocating when fluid came up from his elbow being in her throat.

During Youth A's interview on 1/31/18 she was asked about the incident with Mr. Burch and Youth B. Youth A stated Youth B was in the back room and she was in the room across the hallway. Mr. Burch was back by Youth B's room one on one with Youth B which is not allowed. She said she went back to her room because she could hear Youth B tell Mr. Burch to get off her. She said she saw Youth B swing at Mr. Burch then Mr. Burch attempt to do a standing hold. Youth B was then pushed onto the bed and hit multiple times in the head by Mr. Burch's elbow. Youth A stated Mr. Burch will sometimes play that he is hitting them with his elbow by hitting his hand with his elbow near their face. She said it was like that only he was not playing and he actually hit Youth B in the head.

Youth A stated Mr. Burch was standing in front of Youth B who was sitting on the bed. Youth B tried to fight back by pushing Mr. Burch away. She stated Youth B did this by pushing on Mr. Burch's stomach. She stated Mr. Burch hit Youth B in the cheek, which ended up "big and swollen."

Youth A stated no one besides her saw the incident with Mr. Burch and Youth B. She said Ms. Collins and Mr. Hadley came back to check but did not see the entire incident.

Staff member LaTonya Collins was interviewed. She stated Youth B was restrained by Mr. Burch in her bedroom. Mr. Burch was sitting in the hall outside Youth B's bedroom. Youth B tried to close her door but they are not allowed to have the door closed due to self-harm, so Mr. Burch kept her from closing the door by holding onto the door. Youth B then swung at Mr. Burch and kicked him. Ms. Collins called for other staff and Youth B went to sit on her bed. Ms. Collins stated she and Mr. Burch stood in Youth B's doorway. Youth B sat on her bed spiting and kicking out at Mr. Burch as he approached Youth B. Mr. Burch turned to walk away as Youth B tried to kick him. Youth B then grabbed onto Mr. Burch's coat from behind and he fell onto Youth B's bed. Ms. Collins stated Youth B was on her back and Mr. Burch fell onto his side next to her. Youth B said Mr. Burch elbowed her in the head but Ms. Collins stated she did not see what happened. She went to call other staff and Mr. Johnson came in to help. As far as Ms. Collins could see Mr. Burch was holding Youth B's arms with his arms. Youth B was kicking and flailing. Mr. Johnson tried to grab Youth B's legs.

Ms. Collins stated Youth B did have a knot on her head but she did not know where it came from. After the restraint Ms. Collins stayed with Youth B.

Ms. Collins stated Mr. Johnson and Mr. Hadley were both there and she believes that all the residents were down the hall in the living room.

Ms. Collins was asked why she did not help in the restraint and she stated she did not want to get involved as she has been assaulted in the past.

Staff member Damian Johnson was interviewed. He stated he works with Youth B's group. He stated he was in the kitchen when he was called out to assist Mr. Burch with Youth B. He stated all other residents were in the living room.

Mr. Johnson saw Ms. Collins in Youth B's room and Mr. Burch was restraining Youth B. He said it was a "modified upper torso" with Mr. Burch kneeling on the bed and Youth B laying on the bed. Mr. Burch was next to Youth B with his arms under her arms holding them. Youth B was on her side and was telling him to get Mr. Burch off her. Mr. Johnson said he pulled Mr. Burch away from Youth B but Youth B slapped Mr. Burch so Mr. Burch put Youth B back into the hold. Mr. Johnson again pulled Mr. Burch away from Youth B. Mr. Johnson stated he did this because it wasn't the right hold. He pulled the two apart and Mr. Burch left the room.

Mr. Johnson stated Youth B claimed Mr. Burch punched her. She told him this right after the restraint but he did not see an injury. Mr. Johnson said he knew there was an injury because Ms. Collins was getting Youth B wet towels. He talked to Mr. Burch afterwards and Mr. Burch said "she spit in my face." Mr. Johnson stated all other residents were in the living room watching a movie.

On 1/31/18 Mariannne Burmingham, Quality Control, at Sequel Youth Services was interviewed by the DHHS Worker. Her notes are summarized as follows:

> Ms. Birmingham reported that she followed up with Mr. Johnson after (this consultant) expressed concerns about the restraint. She reported anytime that they have information that a restraint was less than a perfect restraint they try to debrief. She reported Mr. Johnson told her a single person upper torso hold was used. She reported this hold is usually used when the youth is in a standing or sitting position. Because Youth B was laying on her side Mr. Johnson said he wasn't trained to restrain youth on their side. She reported she followed up with the Safe Crisis Management (SCM) trainer on campus and asked them about the application of this hold on the bed and was told it was an acceptable hold per SCM and was the right hold for the situation.

The DHHS Worker also interviewed staff member Mark Hadley.

> Mr. Hadley was asked if he was aware of any restraint with Youth B that occurred in the bedroom and he reported he was. He reported he had been passing out medication. The policy when medication is being passed out is that no child can be in their rooms. All the kids are supposed to be in living room and quiet so focus can be on passing out medication. Youth B got upset about something and went to her room. Because he was in charge of the medication cart he could not leave the area so Mr. Burch went to go talk to Youth B. He could see Mr. Burch sitting outside Youth B's door. The next thing he knew Ms. Collins was yelling. He knew Youth B had thrown something from her room because he could hear the bang and it grabbed all the girls attention and they all looked. The other girls in the group told him they saw Mr. Burch get hit with whatever Youth B threw.

When he looked in the hallway he could see both Mr. Burch and Ms. Collins in the hallway. He heard Ms. Collins say please stop. He then heard Ms. Collins call for Mr. Johnson. Mr. Hadley remained where he was monitoring the medication cart and the rest of the girls. He reported that he only went down to the room after the restraint when he knew Mr. Burch had come out of the room. Youth B told Mr. Hadley Mr. Burch had hit her and she was going to get him fired. He did not hear any other details from Youth B about what happened because she was focused on wanting to call her dad.

When Mr. Hadley was asked if he was aware of any injuries he reported it was hard for him to say if she did because Youth B is a self-harmer. She has a lot of marks on her that she has caused herself. She has what looks like a red rash on her neck but he doesn't know when this developed or why. Youth B's mouth was bleeding and he believes Ms. Collins administered first aid by giving her water to rinse her mouth. He believes it was coming from her lip. She didn't complain of any pain or injuries to him. When Mr. Burch left the room he left because he was angry. He reported none of the other girls were in the room with Youth B. Youth A did go down the hallway but never made it to the room before he verbally told her to come back.

Per the DHHS Worker who viewed Youth A and Youth B's bedrooms she stated Youth A could not have seen into Youth B's room when she was being restrained by Mr. Burch. Pictures of Youth B's room showed Youth B's bed on the same wall as the door. Youth A would have had to be in the doorway to see Youth B get restrained.

Tony Bentley, Human Resource Director, reported he is an SCM trainer at the agency. He stated he debriefed with Mr. Burch about the restraint that occurred with Youth B in the bedroom. He said he agreed with Mr. Burch's decision to supervise Youth B in the bedroom. The girls in the cottage have been creating diversions and Youth B has a history of self-harming. Youth B did not respond to attempts to get her verbally to leave the room. Youth B then became aggressive. The staff was then correct in utilizing proximity prompts in response to her aggressiveness. Because Ms. Collins did not support Mr. Burch it left him in a one on one situation. It is his understanding attempts were made to position her off of the bed but she began fighting. At that time, Ms. Collins did not assist Mr. Burch. Mr. Burch tried to put Youth B in an upper torso assist and ended up on the bed because she fell back on her side. Mr. Burch then had her in an upper torso hold on the bed. When he reviewed the restraint Mr. Burch had to make a decision in a short period of time during the situation. Mr. Burch used a hold he was taught in training he just used it on different terrain (bed). Mr. Bently said had Ms. Collins assisted they would have been able to move her onto the floor.

The interview with staff member Davonte Burch occurred on 2/13/18. Mr. Burch stated he is assigned to work Kresge Unit and mostly works PM shifts. On the day of the incident with Youth B he said Youth B went back to her room when she was

supposed to stay in the front of the unit with the rest of the group. Mr. Burch was asked to check on Youth B by another staff. He went back and found Youth B's light was turned off so he turned it on. Youth B slapped Mr. Burch's hand away and turned the light off. Mr. Burch once again turned the light on. Ms. Collins came by to see what was going on and told Mr. Burch to sit by Youth B's door out in the hallway. While he sat in the hall Youth B threw a blanket at him and spit at him. Mr. Burch then approached Youth B and "got into her space" while Youth B was on her bed. As he approached Youth B she kicked Mr. Burch. A restraint was attempted by Mr. Burch. He stated he tried to get Youth B off her bed in order to get her in a better restraint but she fought him. He stated he held onto Youth B's arm while they both sat on the bed. Mr. Burch stated Ms. Collins attempted to get Youth B's other arm into the hold. Youth B spit in Mr. Burch's face and when he went to wipe it off Youth B bit him in the arm. Mr. Burch pushed his arm into Youth B's face in order to get her to release the bite.

Mr. Burch stated he initially approached Youth B because she was not allowed to be in her room and he wanted to "make her uncomfortable" so she would either decide to comply and go up front or she would be restrained. Mr. Burch said Youth B was needed in the front of the cottage because she was requiring a staff to be away from the group making it potentially unsafe for the group. He stated there were about nine girls and four staff. He and Ms. Collins were with Youth B, Mr. Johnson was in the kitchen preparing dinner. Mr. Hadley was passing out medication and another staff, he thought was Ms. Vondy, was in the living room by the door. The rest of the group, with the exception of Youth B, was in the living room.

Mr. Burch stated their training does not train the staff on how to restrain on a bed; that is why he was trying to get her off the bed. He also said they are not taught a bite release technique in the Safe Crisis Management (SCM) training. Mr. Burch said he has been told by other staff to press into the bite to release the youth's jaw.

Mr. Hadley was interviewed this time by this consultant. Mr. Hadley stated he knew Youth B was assaulting Mr. Burch because he could see her throwing things at him in the hallway. He stated it is their practice when the girls refuse to come out of their room during medication dispensing that the staff are to ask the youth to come out, then if they refuse, the staff are to sit by the resident's door.

During a preliminary Exit Conference on 2/13/18, with Mr. Cox and Mr. Copas, they indicated the story given to them by Mr. Burch was not the same as the one given to DHHS and this consultant. They stated Mr. Burch informed them that he approached Youth B to prevent her from harming herself.

A review of the facility's Emergency Safety Physical Intervention policy was conducted. The policy states:

> "A Starr Albion Prep student may only be placed in an Emergency Safety Physical Intervention if they are displaying behavior that meets one or more of the following criteria;

1. A danger to himself,
2. A danger to others,
3. A serious disruption that can reasonably (imminent and immediate) result in harm to self or others,
4. Destroying property that can reasonably (imminent and immediate) result in harm to self or others."

During a telephone conference with the facility on 4/13/18, the facility's management team indicated that Mr. Burch handled the situation with Youth B according to their policy and training. This was based on Youth B's past behaviors of self-harm, creating diversions so other youth could AWOL and the lack of safety created by having her door closed. They referenced that the prior facility's documentation as well as their own provides detail as to the treat Youth B posed to herself and others by being away from the milieu. It was stated that while her immediate behavior may not seem to be a risk, her past behaviors warranted staff engaging with Resident A due to a history self-harm and creating diversions for other residents.

A review of documents from Youth B's case file was conducted by Area Manager Claudia Triestram. She noted the following information:

Initial Behavior Support Plan
- Staff should check in on her and provide positive encouragement often
- Patience; may need directions/expectations repeated several times
- May benefit from visual aids/prompts
- Fears male interaction
- Requires time to process information or direction given

The CCI's ISP indicated the following:
- Staff should be patient with Youth B
- Staff will help Youth B explore her emotions with by prompting with questions about the emotion behind her feelings and actions.
- Staff will assist Youth B when she is having trouble expressing her feelings to staff and peers.
- Staff will model authentic communication with Youth B.
- Intervention strategies: encourage her to write letter, write in journal or draw, offer one on one support, set firm boundaries, encourage her to explore positive thoughts, use prompting, model appropriate coping skills, provide appropriate choices to foster a sense of independence

Starr ISP:
- Staff will provide support and skills to help Youth B cope effectively with her emotional distress.
- Youth B will learn relaxation methods, such as focused breathing, progressive muscle relaxation, and visual imagery

- Staff will role model appropriate means of handling stressful situations by demonstrating healthy coping skills
- Staff will teach, model, and help Youth B practice various coping skills so that she can choose five that work for her.
- Staff will verbally offer alternative behaviors when inappropriate (boundary invasions, negative comments, swearing, etc.) interactions are observed.

Starr USP:

- Youth B has struggled regulating her emotions at times, but can be deescalated and redirected most of the time.
- Despite UIR (refused meds & aggressive with staff), can be observed as pleasant and following directions.
- Maladaptive behaviors have increased since admission

Unusual Incident Reports:

- She ran with 2 other youth and it was a 4th who created a distraction for them to do so. She came back without incident, stating she left to have fun.
- Staff should have looked to what was going on in the moment as Youth B is not typically aggressive.
- Peers were antagonizing Youth B and she was "getting up and arguing ready to fight one of her peers" and she was restrained.
- Pulled fire alarm and she and peers left facility. She returned after 20 minutes
- No de-escalation was done following any of the incidents.

Ms. Triestram indicated in her e-mail that there was no indication in any of the documents she viewed that Youth B creates diversions for her peers to AWOL or engage in other unwanted behaviors. There was no indication, in this situation with Mr. Burch, that he attempted any of the strategies outlines in Youth B's case file.

APPLICABLE RULE	
R 400.4158	**Discipline.**
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of corporal punishment inflicted in any manner.
ANALYSIS:	Youth B stated Mr. Burch elbowed her in the face. Mr. Burch stated he did not hit Youth B with his elbow. Ms. Collins stated she did not see Mr. Burch hit Youth B. There is not enough evidence to indicate Mr. Burch purposely tried to harm Youth B.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.4112	**Staff qualifications.**
	(1) A person with ongoing duties shall have both of the following: **(a) Ability to perform duties of the position assigned.** **(b) Experience to perform the duties of the position assigned.**
ANALYSIS:	Ms. Collins was present and available to assist, but stated that she did not want to get involved in the restraint with Youth B. In Mr. Bentley's assessment of the restraint he felt that Ms. Collins lack of involvement in the restraint caused Mr. Burch to have to restrain Youth B on his own.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.4159	**Resident restraint.**
	(1) An institution shall establish and follow written policies and procedures regarding restraint. These policies and procedures shall be available to all residents, their families, and referring agencies. **(2) Resident restraint shall be performed in a manner that is safe, appropriate, and proportionate to the severity of the minor child's behavior, chronological and developmental age, size, gender, physical condition, medical condition, psychiatric condition, and personal history, including any history of trauma, and done in a manner consistent with the resident's treatment plan.**
ANALYSIS:	Mr. Burch stated Youth B went and sat down on her bed then he approached her in order to get her to comply or be restrained. He said he did this because it was causing a staff to be away from the group, potentially making things unsafe. This violates the facility's policy which states restraints can only occur if someone poses an "imminent and immediate" risk. Per interviews with Mr. Burch and Ms. Collins, Youth B went and sat on her bed and then Mr. Burch restrained her. While she had thrown something and spit at Mr. Burch, she was at this point sitting on her bed. Entering the room to restrain her was not warranted and per all interviewed, escalated the situation.

	Documentation provided by the agency in response to this initial citation does not support staff's need to engage with Resident A once she went to her room. Once staff engaged with her, she became aggressive towards staff, which resulted in a restraint. While there was some self-harm documented in her file, there was no documentation that Youth B could not be in her room. There was also no documentation that Youth B creates distractions for other youth to AWOL. On the contrary, Youth B went AWOL on one occasion when another youth was creating a diversion. Additionally, the strategies from Youth B's behavior plan were not sufficiently utilized prior to her being restrained.
CONCLUSION:	**VIOLATION ESTABLISHED**
TECHNICAL ASSISTANCE:	Staff should receive training from those writing individual youth behavior support plans so they have an understanding of and can effectively utilize supportive techniques when youth are escalated. Reports from other agency's that document effective strategies should be reviewed and incorporated as appropriate to provide the most consistency for the youth. Staff should then report back to therapists and case managers on a regular basis the effectiveness of the strategies they utilize with youth so therapists can better assess residents' behaviors and needs, and reassess action steps for staff as necessary.

ALLEGATION:

A resident indicated she was elbowed in the face by Ms. Hunt.

INVESTIGATION:

Youth A said she had issues with the Cottage Coordinator Ms. Hunt. She said Ms. Hunt is rough during restraints. She stated Ms. Hunt hit Youth B after Youth B swung at Ms. Hunt. She reported Youth B was bleeding and had a swollen lip.

Youth B was checked on to ensure she was safe. She stated things are horrible for her at the facility and staff are "insane." She stated Ms. Hunt "busted up" her lip trying to put her in a restraint. She also stated Mr. Burch elbowed her in the head.

During her interview on 1/31/18 Youth B reported an incident involving a staff member named Ms. Hunt. She stated Ms. Hunt elbowed her in the mouth. She stated it happened when Ms. Hunt went to restrain her. Youth A stated she did not know why she was restrained. She stated there were two other staff present; Ms. Schleede and Ms. Vondy.

When asked to describe the incident she stated “I don’t know” and “it was too long ago.” She did state that this restraint happened in her bed. She said she was kicking and flailing then was put in a restraint. She said she was half on and half off the bed with her legs kicking and flailing and her arms were holding onto the bed.

During Youth A’s interview she stated Ms. Hunt walked into Youth B’s bedroom after Youth B walked out of the living room. Youth B told Ms. Hunt to leave her alone but Ms. Hunt would not leave her alone. She stated Ms. Hunt gets in their faces a lot. When Ms. Hunt got in Youth B’s face Youth B hit her. Ms. Hunt told Youth B “hit me again and I’ll knock you out.” Youth B swung at Ms. Hunt and Ms. Hunt hit Youth B in the lip.

Youth A stated she saw the incident with Youth B and Ms. Hunt from her bedroom which was across the hall from Youth B’s bedroom. Youth A stated she did not talk to Youth B about the incident but she did talk to Ms. Webster. She stated Ms. Webster quit her job and told Youth A that she quit because the staff were “putting their hands on them too much.” She stated Ms. Webster used to be the groups Senior Clinician and individual therapist.

The DHHS Worker interviewed staff member Tiffany Vondy on 2/1/18. Her notes are summarized below:

> Ms. Vondy reported she was there when Youth B was restrained in her bedroom by herself and Ms. Hunt. When asked what happened she said Youth B was being physically aggressive by swinging her hands and kicking her feet. Youth B was sitting up in her bed, then stood up and lunged and then ended back up in her bed kind of sitting. Ms. Hunt ended up on one side of Youth B and she was on the other side of her restraining her. Ms. Schleede was holding Youth B’s legs. Ms. Vondy stated she doesn't remember all the reason why they were in the room but Youth B has a history of self-harming and they were worried. She cannot remember if Ms. Schleede was in the room the whole time but she thinks Ms. Hunt was in the room the whole time.
>
> Youth B hit Ms. Hunt in the nose. She could not remember exactly but she thinks they initiated the restraint when Youth B hit Ms. Hunt but she is not positive. She reported it was either her or Ms. Hunt who initiated the restraint. The restraint was a supine restraint. They had attempted to do a standing hold when she first stood up but she ended up falling back onto the bed and was still trying to strike them. Youth B physically struggled the entire time. Ms. Vondy grabbed Youth B by her lower arm with her hand. Ms. Hunt had the same grip on the other side. As they started the restraint they moved the bed a little away from the wall.
>
> The restraint did not last long because Youth B stopped and started crying. Ms. Schleede took over the arm for Ms. Hunt and Ms. Hunt left the room. She doesn't recall Ms. Hunt having any other physical contact with Youth B other than

grabbing her arm on the restraint. She reported that she doesn't really know if Youth B got hurt at all. Youth B did have a mark on her lip. The mark looked like from a cracked lip and not really like a cut. Ms. Vondy did not know if this happened because of the restraint or from another restraint or because of cracked lips.

The DHHS Worker interviewed staff member Kendra Schleede on 2/1/18. Her notes are summarized below:

Ms. Schleede was asked if she participated in any restraints with Youth B in the bedroom and she did with one restraint. She reported that it was Ms. Hunt, Ms. Vondy and herself. One of Youth B's peers had said Youth B had something in her hand she could use to self-harm. Youth B has a history of self-harming so she is on very high awareness. To try to prevent any self-harming she was put on suicide watch so they were going to remove stuff from her room.

They were starting to take stuff out of the room when Youth B started punching and kicking them. She reported they went to put her in a supine on the bed. Ms. Hunt was hit in the face. Ms. Hunt and Ms. Vondy immediately went to do the restraint. They had her arms and Ms. Schleede had her legs.

Ms. Schleede reported she had initially been sitting by the door because all the staff were in their positions since it was the evening. She heard loud yelling from Youth B and went down to see what was going on. Two of Youth's B's peers were in the room and were asked to leave. When Ms. Schleede went down there it was her and Ms. Vondy. Ms. Hunt came after when she kept hearing the yelling. Youth B was acting like she had something in her hand and when she refused to show or give it to staff it was decided they would remove stuff to ensure she could not hurt herself.

The only physical contact any of the staff had with Youth B was the restraint. Ms. Hunt did not have any physical contact with Youth B other than grabbing her arm. Ms. Hunt left the room as soon as she got off the restraint. Ms. Hunt was hurt in the nose and Youth B had a cut on her lip. She saw Youth B's lip was bleeding while in the restraint. She gave Youth B a cold wash cloth after the restraint. Ms. Schleede stated Youth B was being highly aggressive the entire time and she believed the lip was hurt during the course of the restraint. No other residents were in the room during the restraint.

Chala Hunt's personnel file was reviewed. She had a discipline and note on her evaluation about being counter aggressive with residents. Her last SCM refresher was 5/24/17.

Per the DHHS Worker who viewed Youth A and Youth B's bedrooms she stated Youth A could not have seen into Youth B's room when she was being restrained by either Mr. Burch. Pictures of Youth B's room showed Youth B's bed on the same

wall as the door. Youth A would have to of been in the doorway to see Youth B get restrained.

APPLICABLE RULE	
R 400.4158	**Discipline.**
	(2) An institution shall prohibit all cruel and severe discipline, including any of the following: (a) Any type of corporal punishment inflicted in any manner.
ANALYSIS:	All the staff involved in the restraint indicated the cut to Youth B's lip was either due to dry lips or accidental in the course of the restraint. Youth B also never indicated Ms. Hunt intentionally hit her but rather she was bumped by Ms. Hunt's elbow in the course of the restraint.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During his interview Mr. Burch indicated there was not enough staff to effectively deal with the behaviors of the youth. During the incident on 1/9/18 with Youth A, Mr. Burch stated he had to restrain Youth A by himself because there was not enough staff to assist him.

For the incident on 1/20/18 with Youth B, Mr. Burch stated Youth B was needed in the front of the cottage because she was requiring a staff to be away from the group making it potentially unsafe for the group. He stated there were about nine girls and four staff there that night.

During her interview Ms. Collins stated she was present for the restraint with Youth B on 1/20/18 but she did not assist with the restraint.

Mr. Cox and Mr. Copas were asked about the number of residents and the number of staff on shift during both incidents with Mr. Burch. It was reported that there were nine girls on the 9th when the incident with Youth A occurred and ten on the 20th when the incident with Youth B occurred. Mr. Copas had the hours staff clocked in checked for both of those shifts and found there were five staff on both shifts. There were discrepancies between who Mr. Copas stated was clocked in and who the staff said actually worked or did not work on those nights.

Mr. Cox stated the ratio for this group of girls is one staff to four girls. The night of the restraint with Youth A and Mr. Burch there were nine girls. Mr. Copas stated there were five staff clocked in for that shift. The staff were Mr. Hadley, Mr. Burch, Ms. Vondy, and Ms. Hunt. The night of the incident with Youth B and Mr. Burch there were ten residents and five staff clocked in. The staff clocked in that night were Ms. Fischer, Mr. Johnson, Mr. Hadley, Mr. Burch, and Ms. Collins.

Staff member Stephanie Fischer was listed as one of the staff working the night of the incident with Youth B and Mr. Burch (1/20/18). When Ms. Fischer was interviewed on 2/28/18 she stated she does not recall working with Mr. Burch until last week. She said she does not remember ever seeing him in a restraint.

Ms. Fischer was asked about staffing and she stated there was one time they were short by one staff but Ms. Carpenter was in and out. She said there were three staff that shift. Ms. Fischer stated when they have three staff there is not enough staff to deal with behaviors. She stated on the weekend they have four staff and she feels that is enough. She stated they currently have 11 residents.

Staff member Mark Hadley was interviewed. Mr. Hadley was listed as working on both 1/9/18 and 1/20/18. Mr. Hadley stated he does not think he worked the day the tables were flipped (1/9/18). He said he heard about it the following day. He stated he does not work on Tuesday's and January 9th was a Tuesday.

Mr. Hadley stated he did work on the 20th but said Ms. Fischer did not work that day. He stated Mr. Johnson, Ms. Collins, and Mr. Burch worked with him. He stated they had enough staff to supervise the girls and deal with Youth B's behaviors.

Staff member Chala Hunt was interviewed. She stated she was not working the day the tables were flipped (1/9/18). She stated she found out about the incident the following day. Ms. Hunt stated she does not recall if she worked at a different cottage or if she worked in the morning that day.

During her interview on 3/19/18 Ms. Schleede stated that she worked the night of the restraint with Mr. Burch and Youth A. She stated Ms. Collins also worked. Ms. Schleede stated there was only the three of them on shift that night and that was not enough staff. She stated the girls on Youth A's unit require four or five staff in order to deal with their behaviors. Ms. Schleede stated the "higher ups" have instructed the staff to make sure one is in front of the exit door and one in front of the fire alarm that releases the doors. Ms. Schleede stated she was in front of the exit and Ms. Collins was in front of the fire alarm. This left Mr. Burch to deal with behaviors on his own.

Mr. Copas forwarded an employee time sheet for 1/9/18 which he indicated by check marks that Ms. Hunt, Mr. Burch, Mr. Hadley, Ms. Vondy, and Ms. Schleede worked on 1/9/18. The list did not indicate what times these staff worked. Other staff were listed with hours they worked on this day, including Ms. Collins.

APPLICABLE RULE	
R 400.4126	**Sufficiency of staff.**
	The licensee shall have a sufficient number of administrative, supervisory, social service, direct care, and other staff on duty to perform the prescribed functions required by these administrative rules and in the agency's program statement and to provide for the continual needs, protection, and supervision of residents.
ANALYSIS:	During the incident on 1/20/18 Ms. Collins was present to assist with the restraint. This indicates there was enough staff to manage Youth B's behaviors. Time sheets for 1/9/18 indicate there were multiple staff working; however, the times and location those staff worked is unclear. It cannot be determined which staff worked in that cottage during the time of the incident. The staff interviewed that were working state there were only three staff working the shift on 1/9/18, which those staff indicate was not enough to manage the resident's behaviors. Even if the cottage was within the required ratio at the time, the staff working were not sufficient in number and/or experience to successfully manage the needs of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**
TECHNICAL ASSISTANCE:	It is recommended that the facility have more experienced staff who have the ability and the knowledge to address the difficult behaviors of this population as well as successfully implement therapeutic goals and behavior plans to address the needs behind the acting out behaviors. It is further recommended that the facility add a bite release into their physical management training.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan it is recommended that this investigation be closed with no further licensing action.

5/18/18

Rorie Dodge-Garnaat Date
Licensing Consultant

Approved By:

June 12, 2018

Claudia Triestram Date
Area Manager